CONNECTING CARE PODCAST // EPISODE #15 // TRANSCRIPT

Pathways to care: Improving methadone access under existing regulations

Dr. Alex Walley:

Methadone can be a life changing, and sometimes life saving treatment option for people with opioid use disorder. Unfortunately, a number of federal and state regulations and logistical requirements can inhibit a person's ability to start or maintain methadone treatment. There are regulation exceptions that can help people get the essential care they need. Some providers are using these exceptions to initiate methadone while still honoring the regulatory boundaries.

Dr. Jessica Taylor:

Really, to address what are now being described as syndemics, the epidemics of opioid use disorder, as well as increasing HIV transmission among people who inject drug; we have to think about these things together and deliver the services in an integrated way because the old system of this siloed care just is system-centered, not patient-centered, and it really hasn't gotten us to the goal of preventing HIV transmission or preventing opioid overdose.

Dr. Alex Walley:

You're listening to Connecting Care. I'm Alex Walley, an HIV primary care doctor and addiction medical specialist in Boston, Massachusetts. This month, my colleague, Dr. Jessica Taylor and I talk about current regulations directing how and when people with opioid use disorder can access methadone treatment, what clinics can do to deliver lifesaving care without stepping outside the lines, and how methadone enhances HIV treatment and prevention.

Dr. Alex Walley:

You're listening to Connecting Care: The intersection of HIV and opioid use disorder. I'm Alex Walley. I'm an HIV primary care doctor and addiction medicine specialist in Boston, Massachusetts. Today, I'm joined by my colleague, Dr. Jessica Taylor, and today it's just the two of us. Our usual colleague, Sim Kimmel, is taking care of patients on the infectious disease service at Boston Medical Center, and we're not going to have a guest today. And that's because we really want to talk even more about methadone.

Dr. Alex Walley:

So, the frequent listeners will remember that we have covered methadone in the past, but it's been a while in the past and some new things have happened. We think that they are important, not only for people with opioid use disorder, but also for people with HIV. So, Jess. Can you remind us, and maybe summarize what we've covered previously about methadone on Connecting Care?

Dr. Jessica Taylor:

Sure. I would say our biggest methadone related podcasts were last June and July, numbers six and seven if folks are looking at the list of episodes. And what we essentially did was, we talked about how methadone has become even more relevant now in the era of fentanyl.

Dr. Jessica Taylor:

Methadone is our longest standing medication for opioid use disorder, and arguably our most effective medication for opioid use disorder. And what we've seen in the last couple of years with the arrival of fentanyl is that it is harder to get onto buprenorphine. And we're hearing that because that's harder, people are therefore more interested in methadone. So, we talked about those dynamics.

Dr. Jessica Taylor:

We heard from a colleague, Hiawatha Collins, who is a community mobilization coordinator at the National Harm Reduction Coalition and the board chair of VOCAL New York. And we heard about his experience as an organizer, as an advocate, and as a person who's been on methadone; in terms of the patient experience, the impacts of our current methadone policies, the restrictions, and how we have this medication that's so effective but yet is so regulated and so structured that everyone who stands to benefit is not necessarily able to access it.

Dr. Jessica Taylor:

And we followed that up in episode seven by talking about a little use pathway to delivering methadone to people who are exp answering opioid withdrawal in an emergency or urgent setting, known as the 72 hour rule. And at the time we recorded the episode, we had just done a first pilot case in our bridge clinic, which is not licensed as a methadone clinic. It's not an opioid treatment program. But we had just piloted using this pathway and the 72 hour rule to treat a patient's opioid withdrawal while we linked her to a methadone clinic for long-term care. And we talked a little bit about that regulation and what it meant to the patient, what the outcomes were, which in that case was that she was retained in care at the methadone clinic and has done incredibly well.

Dr. Jessica Taylor:

And so, that's really where we left off on the methadone policy discussions. I think we were pretty hopeful at that point that we would see regulatory change that may come through at both the federal and state levels to really make methadone more accessible and eliminate some of the barriers that we know keep people from being able to get this medication. And so, I'm glad we're having this conversation because I think this is a good time to check in with one another and with the group and talk about some of the changes that have happened, some of the things that we're still advocating for and really hope to see happen very soon. And then also, really zero in on what we can accomplish now within existing regulations.

Dr. Alex Walley:

It's a very fond memory that we had Hiawatha Collins on the episode, and I think you nailed most of the high points. One of the things that struck me was our discussion about the stigma of methadone. So, we know that substance use is highly stigmatized. It's criminalized, which is the greatest form of stigma, is to criminalize something. And that stigma of the substance often taints the way that we see the people who use the substance. And then, the real irony or shame of methadone is that it is as a treatment stigmatized, both by medical providers and the general public, but also even by people with opioid use disorder. People who use drugs, also there's a lot of stigma. And so, I'm particularly grateful to Hiawatha for him coming on a podcast and talking about his experience and his advocacy, because it's so crucial.

Dr. Alex Walley:

Another thing I think we did was dream a little bit about what we would like to see, and I think most of today we're going to focus on, what are the practical things that can be done now? But I think we should take just a second to think about, if we could redesign the system so that a lot of the barriers weren't

there, what would it look like? And so, if you could redesign the system, how would you want to be able to treat people with methadone, or how would you want to make methadone accessible?

Dr. Jessica Taylor:

I think for me as a primary care doctor and an HIV doctor that does outpatient medicine, for me to be able to prescribe methadone would really be the fundamental reform that would enable the people that I care for to get the care that they need, and would address a lot of the stigma pieces that you're talking about by allowing patients to receive their methadone, where they receive all of their other medications, which is a pharmacy. That's where we pick up medications for all of the other chronic conditions that our patients have. And so, I think what we face right now is these really siloed systems where methadone, due to stigma, has been separated from traditional medical care, from the medical model, and that contributes to a lot of the barriers that we talked about.

Dr. Alex Walley:

It's really a separate and unequal treatment. Separate in the sense that it's segregated and completely siloed.

Dr. Jessica Taylor:

There's no other example of it in medicine.

Dr. Alex Walley:

Right.

Dr. Jessica Taylor:

It is so separate that methadone doesn't even appear in prescription monitoring programs necessarily, and there's pros and cons to that we could discuss, but it is possible to have your methadone care entirely divorced from all of your other clinical services, and we do that because we stigmatize methadone treatment and opioid use disorder.

Dr. Jessica Taylor:

So, yeah. As an addiction specialist and someone that uses my methadone, and I don't work in a methadone clinic, but I do work with methadone; I'd feel very comfortable prescribing it in an outpatient setting if that were possible, if that were allowable under regulations, and can see tremendous benefit to bringing it into the fold of HIV care when I'm in the ID clinic of primary care and primary care settings. And really making it a part of the other things I do with my patients, such as prescribe HIV treatment, such as prescribe HIV prevention medicines, and having the flexibility to really adjust the amount of support to a patient's need.

Dr. Jessica Taylor:

Because right now we have essentially, even with some of the rules around being able to earn things like take home doses where patients don't have to go to the clinic every day, we have a pretty much a one size fits all approach. And the problem is, it's one size fits none in many cases, where it's very structured and people that may not need or want to go to the clinic every day are still required to.

Dr. Jessica Taylor:

My wishlist item would be the ability to prescribe methadone for opioid use disorder in an outpatient clinical setting that is a medical setting, a primary care setting, my HIV clinic, and have my pick up their medication at the frequency that the patient and I decide together is appropriate at a retail pharmacy, at a hospital pharmacy.

Dr. Alex Walley:

I love that vision. I share it. I'll take another venue and just talk about it for a moment. So, not only is methadone segregated from medical care and psychiatric care, it's actually segregated away from other addiction care settings. So, typical addiction care settings would be a intensive outpatient program where people go for counseling or other counseling that is, say, weekly. Intensive outpatient is usually a two to four week, 20 hours a week of group in individual counseling. There's residential addiction treatment programs that provide residential care, which also includes counseling, case management, individual one-on-one, group work, family work. Those settings class do not encourage or provide access to methadone treatment, which is just bonkers to me because I have patients who I really think need residential care, especially those who are challenged with their housing. Especially people with HIV and have housing challenges, they could really use supportive... For those who want it, a supportive recovery-based environment, and it's very hard to find that where it's actually integrated with methadone.

Dr. Alex Walley:

And so, there actually aren't regulations that prohibit that, and what we're going to talk about that a little bit more later. But just as we're envisioning an ideal system, I'd like to see other forms of addiction treatment be more welcoming and integrated with methadone care. And similarly, I'd like those systems like methadone clinics, and there's some examples of this in the Bronx, but I think that's one of the only places that I'm aware of in the country where a methadone clinic can actually provide more medical services.

Dr. Alex Walley:

So, the way that methadone clinics tend to be so segregated, and this is more of a payer issue than a regulatory issue, I believe; that the way that methadone's paid for, it doesn't allow the opportunity for people to get their primary medical care at a methadone clinic, for example. And there's no reason that shouldn't be able to be done there, because there are physicians that are there, there are nurses that are there, they're able to do blood tests. So, they are healthcare settings, but a lot of barriers to them offering the full range of healthcare services.

Dr. Alex Walley:

Since we talked last about methadone, there have been some reforms. One of the things that was in place when we talked last time was this liberalization of the take home policy, and that was expressly put into place because of COVID. It still remains. SAMSA announced in the last six months, the Substance Abuse Mental Health Services Administration that does much of the regulation of methadone treatment programs or opioid treatment programs, OTPs, announced an extension of the liberalization of take homes under the COVID emergency. And we don't know for sure how long those are going to last, but for now they're still in place.

Dr. Alex Walley:

And essentially, what that liberalization has done has instead of it being regulated by SAMSA, the frequency and the requirements for when take homes are allowed, it gives the discretion to the medical

provider at the methadone clinic. And so, clinics are, at the discretion of the medical provider there, are able to grant up to 28 days or a month's worth of take homes to patients. And when the liberalization goes away, the old requirements will go back into place, which is going to require 60 days of continuous day by day attendance at the methadone clinic, will require regular drug testing which shows abstinence in the toxicology testing, and also requirements like having stable housing, which most places interpret that excludes people who are homeless from getting take homes.

Dr. Alex Walley:

And I think one of the biggest barriers is actually a requirement that people attend counseling. And so, I think a lot of methadone treatment providers are anxious about the future when these restrictions come back into place, but for now, the liberalizations remain intact. So, we'll see how long that lasts.

Dr. Alex Walley:

There's two other reforms that have occurred, which is that there's now a pathway for methadone clinics to provide methadone through mobile vans, which has always existed, but there was a moratorium that was placed on new licenses for mobile vans for many, many years. And also, there was a restriction from actually initiating people through mobile vans. They had to be initiated in fixed sites and then only they could get follow up visits in the mobile vans. And the same is true for what's called a medication unit, which is essentially a satellite dosing site for methadone programs. So, those regulations have been liberalized so that they are more readily available, and so that's some hope. But I have yet to see those actually be put into place, even though those regulation changes, or those regulation clarifications came in September of 2021.

Dr. Jessica Taylor:

So, we had heard from Hiawatha about many of the challenges to not just starting methadone, but also staying on methadone through an opioid treatment program. But just to look upstream at really the initiation process for methadone. For folks who may be listening who are not familiar, could you describe what that process is like and what patients go through once they decide that they want to enroll in a methadone clinic and be treated for their opioid use disorder?

Dr. Alex Walley:

Sure. I'd be happy to. This is an ongoing frustration for me. But when I think about my patients, and when I worked in methadone clinics and watched what they go through and then trying to get them access as a provider, as their either addiction provider or their primary care provider or their addiction consult service provider; it just pains me because I know how much patients can benefit from the treatment.

Dr. Alex Walley:

So, there are layers of regulations from SAMSA, from the DEA, from the state agencies that also regulate. So, there's at least three or four layers of regulations that set the standards for people initiating methadone. Then individual clinics and their culture is another layer, which just historically and culturally, clinics have been risk averse due to their concerns about being perceived as sources for diversion. And then there's just a lot of stigma. So, the initial in person visit, which is interpreted widely as being a mandated requirement; that initial in-person visit has not been liberalized during COVID restrictions. So, that has not changed. Whereas with buprenorphine, we can prescribe buprenorphine over the phone to somebody even without seeing them in person, and you can do that with any other medication.

Dr. Jessica Taylor:

And that too was a COVID-era modification, one that we hoped to hang onto long-term.

Dr. Alex Walley:

For buprenorphine, absolutely. But there was no allowance for tele-initiation of methadone. So, all of our patients who've started on methadone, we're going to talk about how many have through the innovations; they've all still had to have an in-person visit at a methadone clinic at some point.

Dr. Alex Walley:

But typically, it's interpreted that before you start methadone, you have to have an initial in-person visit. And that requires, number one, for you to be in withdrawal. So you have to feel terrible, and opioid withdrawal is not a pleasant experience that you've really would wish on anybody who you're trying to care for. They have typically to have three or more interviews; one with a counselor, one with a nurse, and one with a prescriber who's either a physician or a nurse practitioner. Typically, toxicology testing is required. Many clinics require abstinence from other substances, not all clinic, but many do.

Dr. Alex Walley:

There's a medication review, and then there's this process called double enrollment search. So, there's a lot of concern within methadone clinics that people will enroll in two methadone clinics at one point in time. But in most states, there is no system that is readily accessible that allows clinics to check in order to see if they're enrolled in another clinic. And so, what they've done at all the clinics that I've worked at is you have to manually fax releases to the other clinics for them to then fax back confirmation that that person is not enrolled, usually in the local area. And that takes alone an hour or two to run that whole process. A lot of staff hours are dedicated to that.

Dr. Alex Walley:

There's an informed consent release of information that needs to be completed. People are typically asked to commit to counseling. There needs to be this daily, in-person attendance that people have to commit to, particularly at the beginning and before the COVID liberalizations. A major issue that we run into again and again is that a picture identification is required.

Dr. Alex Walley:

And I can tell you that people who are seeking treatment for methadone care are usually at a very low point. It takes a lot for people to seek out methadone care. And many times they're in desperate situations, and having a picture identification is not always something that they're going to have. And so, that becomes a real barrier. And then they get dosed at the end after they've gone through all of this, and it often takes four hours for people to complete this process.

Dr. Alex Walley:

So, they have to come in and withdraw, and then they stay and withdraw, and this is somebody with an opioid use disorder, severe opioid use disorder, and they are conditioned to really fear and try to avoid withdrawal. So, we're asking a lot from people on the first day of methadone., and then when we give them methadone, their dose is capped at 30 milligrams for the initial dose, which in the setting of weak heroin, 30 milligrams is usually maybe adequate, but in the setting of a very strong fentanyl supply, which most of the country is seeing, 30 milligrams is probably a dose that's too low for the first day, and

it sets the level that people are going to be dosed in subsequent days. It then takes time for people to get to a therapeutic dose.

Dr. Alex Walley:

So, all of this really hinges on that in-person initial visit. And so, that's what people have to go through. And it turns out, though, actually, that there are some exceptions to this requirement, and that's what we wanted to talk about today; was to talk about this exceptions to the regulatory requirements for that initial in-person visit, and how you can bypass this. One of the examples that we talked about before was the 72 hour rule where we went through the case. And so, Jess has really been the leader in our area in developing this model. So Jess, why don't you give us an update on where things have been at your clinic with the 72 hour rule?

Dr. Jessica Taylor:

Sure, thanks. And I'll just emphasize that the 72 hour rule, and two other things we'll talk about, are changes or protocols you can implement in your programs now. They're allowable. These are things that we can all be offering and doing in order to make it easier to get in the door and start methadone.

Dr. Jessica Taylor:

So, last summer we had described the very first case of administering methadone for opioid withdrawal in our bridge clinic. Like I said before, we're not an opioid treatment program, we're not licensed as a methadone opioid treatment program. But we did have the infrastructure, we had the equipment that we needed and a few other pieces in place to be able to comply with this regulation, which is called the 72 hour rule; which allows a provider who is not part of an opioid treatment program to administer, but not prescribe methadone, meaning directly give it to the patient under observation, for opioid withdrawal for up to 72 hours while linking to ongoing care.

Dr. Jessica Taylor:

And so, we talked about how in our first case, we had treated a patient's withdrawal. We had reached out to a local opioid treatment program, secured an appointment for her to enroll on the third day in that case, saw her the following day, treated her again. She linked successfully and she stayed at the clinic and has done incredibly well there.

Dr. Jessica Taylor:

That was our first case. It was, I will admit a little bit nerveracking because it was something new to us to be administering methadone, and we had a lot of stakeholders and protocols to get in place of storing the medication in a secure way and documenting administration, and really had a wonderful team come together to develop those protocols.

Dr. Jessica Taylor:

What we saw after that was that the demand for the pathway just really exploded, and we very quickly had a lot of people coming to us saying, "It's just too hard to get on through any other pathway," which is really, really goes back to what Alex was describing as this gauntlet, which is a phrase I've heard him use in the past of the challenges people are faced with when they try to start methadone.

Dr. Jessica Taylor:

So, we had people coming in to see us saying that, "I walked into a local program. They told me that it would be two weeks before I could start there, and I just can't wait two weeks. I'm sick. I'm afraid of overdosing." As often they were describing other practices related to substance use that increase HIV risk, like syringe sharing, for example. And so, we began to offer opioid withdrawal management with methadone more frequently.

Dr. Jessica Taylor:

And we've since had the chance to look at our data a little bit. And what we saw is that we looked at the first 150 encounters that really took place over last spring and summer of '21 through mid-August. And in our first 150 encounters, we took care of 142 patients. And we found that we were actually able to get people into a clinic within the 72 hour period by using a pathway that is allowable now, which is a directed mission pathway.

Dr. Jessica Taylor:

And so, what that means is that usually, like Alex was described; in order to start at the clinic, patients have to schedule an appointment, see the provider at the clinic, and do the physical exam in order to enroll and start dosing. However, it's allowed to do what's called a direct admission, meaning that an outside provider's physical exam serves as the intake exam enabling the patient to enroll, to start getting methadone treatment right away, and then they complete enrollment by seeing the provider at the methadone clinic within a number of days or a short number of weeks depending on the circumstance. But the barrier that goes away is that the patient does not have to wait to see the opioid treatment program's provider to get that first dose at the OTP. And that, in our area where we practice, is really the bottleneck. It's capacity for the OTP providers to be able to enough new patients to get them in the door.

Dr. Jessica Taylor:

And so, in my bridge clinic on the other hand, we don't have the OTP license, but we do have a lot of provider capacity. And we've been able to use that and collaborate with our OTP colleagues to make sure that our intake visits really gives them the information that they need to accept patients as direct admissions. We put some agreements in place with our OTP partners. And so the way it looks is that if is in serious withdrawal, they're at very high risk, experiencing opioid withdrawal, and a good candidate and clinically eligible to go to methadone treatment long-term; we're able to see them, treat their withdrawal for up to 72 hours while we work with our partner clinics, secure them that appointment, and then hand them off by the fourth day at the latest. Meaning, we can treat for up to three days, we hand them off by day four so they have no gaps in their methadone administration and they can start dosing right away. Then they see the provider at the methadone clinic to finish that OTP enrollment as it's available.

Dr. Jessica Taylor:

And so, we've started to evaluate how well this works, because we wanted to make sure that in offering this pathway, we want to help patients get to their goals of getting into the clinic if that's what they're seeking, and want to make sure that we're offering this protocol in a way that's compliant with the regulations. And so, what we've seen so far is that our rates of patients linking to the clinic, meaning that they go to the OTP after we finish care with them and they attend an appointment there for dosing, are really high. So, 87% of the times when we schedule a patient to go to the OTP, they attend that visit.

Dr. Jessica Taylor:

And that's really a number that we're incredibly proud of, and reflects a lot of case management work, reflects a very positive two-way collaboration between the OTPs and our bridge clinic, which is, to say it on this podcast, it sounds like, "Oh, that should be the way it always is." But as Alex was describing the before, typically addiction settings are very siloed and methadone is really excluded from other addiction care settings. So, this feels like a little bit of a breakthrough in terms of being able to support patients in moving between the methadone system as well as the medical system overall.

Dr. Jessica Taylor:

And we've also been really excited to see that 57% of the patients that we refer stay in care at the methadone clinic for at least a month. We're still working on getting follow-up data to be able to update you, and we'll continue to update you as we learn more, and as we have more months of follow-up to be able to tell you if people stay for six months, for example.

Dr. Jessica Taylor:

But right now we've looked at retention at the clinic for up to a month, and the retention rates are really high. So, I think the early signs are that this is an important door to methadone that addresses opioid withdrawal. That's the goal of the regulation, which we really need to treat as an emergency. If someone's an opioid withdrawal, facing, needing to use from a very unpredictable fentanyl supply; the risk of overdose and overdose death is incredibly high, and we need to be addressing opioid withdrawal as the emergency that it is and delivering the care.

Dr. Jessica Taylor:

And so, this remains a workaround. I would like for it to be easy enough for patients to get into the OTP that they don't have to see us for withdrawal management to get this direct admission pathway. But while we wait for that reform, I think this is a really important front door that seems to be meeting meets that our patients have, and seems to be associated with both getting to the methadone clinic and staying there for at least a month.

Dr. Alex Walley:

So, just to recap and summarize. This opportunity, the 72 hour rule, is actually not new. It's been around since 2002. The DEA clarified it in a letter which we posted link to at the podcast website that you can see. And primarily this has been used by emergency departments when somebody presents on a methadone clinic, and for whatever reason, whether it's a natural disaster or whether the clinic has to close for some reason, or whether they maybe miss their dosing time; it allows the emergency department to essentially continue the methadone by dispensing a dose to the person.

Dr. Alex Walley:

But the way the regulation is written and the way it's intended actually is to allow for providers who don't have OTP licenses to treat people in opioid withdrawal with methadone, and then link them to a clinic that will receive them. So, this has been a regulation for a long time, but just rarely used. And it does provide an another pathway around the requirement that it's the methadone clinic's prescriber that has to do that initial intake. And now that there are more and more addiction specialists that are accessible, there's more and more people qualified to do this assessment.

Dr. Alex Walley:

Actually, I reviewed the regulation from the federal government, and they even include a primary care physician being able to do this initial assessment and count for that initial intake. And so, that's something that I really haven't heard and we're not even actually doing. I mean, we staff our bridge clinic with people who are primary care physician and addiction specialists and they do the assessment, but there actually is leeway within the regulations that a lot of programs are not taking advantage of.

Dr. Alex Walley:

Another point I want to just emphasize is that this does all hinge on breaking that siloing or that segregation by having a strong relation ship between the clinic that is doing the 72 hour rule based initiation or treatment with methadone and the clinics that's going to receive them, and that's built on trust. Right now, because I think of the stigmatization of methadone and methadone treatment providers, there isn't a lot of trust either from the methadone treatment provider or from the community providers, and it does take relationship building in order to do this. And so, that's a key point.

Dr. Alex Walley:

And then the third one is, that I can think of, is that you really need to have an institution that is going to be able to keep that medication safe, up to the DEA standards, which are actually are not as high as they are for the opioid treatment program regulations, but are more in line with the standard regulations around keeping controlled substances in a medical setting. There's a DEA license for that clinics can obtain. It's not just limited to hospitals, for example. And so, that's another piece that needs to get worked out, but can get worked out and we're seeing a lot of success. And particularly in our area where there's just so much demand.

Dr. Alex Walley:

I mean, maybe Jess, you want to speak a little bit more to, why do you think so many people are interested in methadone at this point in time? I mean, I know we've covered it in previous podcast, but maybe just as a reminder as to, why methadone now?

Dr. Jessica Taylor:

Sure. Yeah. We're hearing that it is too hard to start buprenorphine because of the fentanyl that's in the opioid supply. Methadone is, it's a full agonist medicine, meaning it binds the opioid receptors fully and there's not this risk of precipitated withdrawal that you can get when you start buprenorphine after using heroin or fentanyl. And so, that has a lot of benefit to people that have had bad experiences in the past just starting buprenorphine too soon.

Dr. Jessica Taylor:

We also think that the crisis of fentanyl and the unpredictable nature of the supply and the risk that's associated with it is... Obviously it has driven the huge surge overdoses that we've seen, which were the highest at any point in U.S. history over the past year. And we think that is really appropriately shining a light on the need to make treatment more accessible, which is long overdue. And I think that's helped us as providers move forward in really thinking creatively about how to maximize the leeway that we have within current regulations.

Dr. Jessica Taylor:

So, I think those factors have come together to really make this the right time to do anything and everything we can under allowable regulations while we continue to advocate to get truly patient-centered care that our patients need and deserve.

Dr. Alex Walley:

The truly patient-centered care is to be able to offer all medications to all patients in the same, in one venue. And I think you said that you're hearing that buprenorphine for some patients doesn't work. I mean, you're not just hearing it, you're seeing it. Because in the same clinic, you're offering buprenorphine, and we're bending over backwards to try to find ways to deliver buprenorphine to people that want it that won't precipitate withdrawal. And some of those techniques are helping, and maybe we'll talk about them in another podcast if we haven't already, and sometimes they aren't working. At the end of the day, we really need to be able to offer our patients choices, just like we do for other treatments, for other conditions to find a treatment that works for them best today, and also be flexible enough to change to another treatment in the future.

Dr. Alex Walley:

And so, when the treatment providers are segregated and only able to offer one of the three FDA approved treatments, then it gets much harder to switch back and forth between a treatment, and that's really the more natural course that people take over their time that they're trying to address their opioid use disorder.

Dr. Alex Walley:

I want to make sure we talk about two other direct admission techniques that are doable under existing regulations where you don't, we don't need to wait for reforms for these to happen. The first one is, I mentioned the residential treatment settings and how they're often segregated. It turns out that in Massachusetts, we have a three step residential treatment system that aligns with the ASAM criteria.

Dr. Alex Walley:

The first step is acute treatment services, also known as medically managed withdrawal, also known as detoxification, which are usually five to seven days. And in these settings, people come in typically for opioid or for alcohol withdrawal. For those who come in for opioid withdrawal, they're often times offered methadone in a methadone taper, where they'll get 30 or 40 milligrams the first day and then tapered down over the next five to seven days.

Dr. Alex Walley:

And the real problem with this is that people leave the residential setting at a higher overdose risk than they came in because the detox has been successful in reducing the tolerance of the person tapering them. And so then they, with less opioid tolerance and a very high likelihood of returning to use after just five to seven days of inpatient treatment, the likelihood of overdosing is much higher because that tolerance is reduced.

Dr. Alex Walley:

And so, what we really should be doing is instead of tapering people, we should initiating and continuing people on methadone. And if you're in a detox program that starts methadone or tapers methadone, you actually have the same regulatory license that an opioid treatment program has, and you're not fixed to taper people. You can actually titrate people, which means initiate the dose they need and

increase them in an inpatient setting, which is a particularly safe setting, and then link them to a outpatient treatment provider at the end of their detox.

Dr. Alex Walley:

And if they want to do residential treatment and go on to further residential treatment at the next level, then ideally they could do that in collaboration with an outpatient OTP and continued their methadone while they're there. That's getting to that integration vision. There's nothing regulation-wise or legal-wise that prevents that progression, and that really is a standard of care that we should be meeting with our patients.

Dr. Alex Walley:

And I don't know, Jess, have you guys had any success in initiate people on methadone, getting them linked to an OTP and also having them go to residential treatment?

Dr. Jessica Taylor:

That is one of the more complicated scenarios that we deal with. There are detoxes or inpatient medically managed withdrawal units locally that offer methadone detox and direct admission from the program, just like you're describing, which needs to be the norm. It is really not acceptable to be treating people for a couple days with methadone, discharging them without linkage to ongoing care. That is beneath the standard of care, and it's a practice that we really shouldn't tolerate in patients that wish to continue methadone and be linked directly. That should be the default for us.

Dr. Jessica Taylor:

One challenge we have is that patients, based on bed availability, often have to travel to different parts of the state in order to get residential services. And that just creates complexity where, if we've sent them as a direct admission from our bridge clinic to an opioid treatment program, and the bed is available 45 minutes away; figuring out how to get the patient fully enrolled in the opioid treatment program quickly, and then setting up guest dosing at a program that might be in a different region is it's complicated. Honestly, it's a pain point for patients that we're caring for that might have unstable housing, that might benefit from residential supports for other reasons.

Dr. Jessica Taylor:

So, I think it really speaks to the need for, again, all care settings to offer all FDA approved medications. We shouldn't be faced with having to send someone further away to a detox that has a bed today that offers methadone because programs that are closer by may not be offering methadone, for example. So, all FDA approved medications in all care settings would really go a long way towards solving some of these challenges.

Dr. Alex Walley:

I couldn't agree more. So, the barriers really are not regulation or legally based. They're really logistically based, and around how systems are organized. So, those of you who have the opportunity to organize systems, this is an opportunity to reorganize, in a way, to make this integrated care more possible.

Dr. Alex Walley:

The third and last setting I wanted to mention was the inpatient hospital, the general hospital. There is a explicit exception that allows for the treatment of opioid use disorder and opioid withdrawal for

hospitalized patients in general medical settings, and that's been the standard of care in our hospital now for many years, but isn't in many other hospitals because of a misperception of what you're able to do.

Dr. Alex Walley:

In many general hospitals, the belief is that you can't continue initiate methadone for opioid withdrawal or opioid treatment, and that can only be done by a methadone clinic or an opioid treatment program. But actually, there is an exception in the regulations that allows for that. And again, with a relationship with a community based clinic, with trust that they'll accept those patients when they're discharged, which is something, again, we've developed at our institution over the last 20 years or so; you actually can do that.

Dr. Alex Walley:

The hospitalized patients with opioid use disorder are some of the highest risk for both complic of their opioid use disorder, as well as complications of their medical conditions. So, these are usually young people who are in the hospital for serious infection or some other illness, their opioid use disorder is treatable, you have the opportunity to treat it while they're hospitalized, and it's going to facilitate the better treatment of the underlying medical condition for which they were hospitalized in the first place. So big opportunity, no regulatory barriers to this.

Dr. Alex Walley:

Jess, you've worked many times on our addiction consult service, any reflections on the direct admission from the inpatient hospital?

Dr. Jessica Taylor:

I feel like I'm parroting what I said a second ago, but it is the standard of care, that it is not acceptable for us to hospitalized patients with infections like endocarditis, like acute HIV infection, like some of the other skin and soft tissue infections that we see; and provide an antibiotic or an antiviral, but not address underlying risk through the opioid use disorder. It wouldn't be a practice that we would tolerate for any other condition. You can't imagine someone being admitted with a heart attack, for example, and not being started on a cholesterol medicine.

Dr. Jessica Taylor:

And so, we all really need to advocate to make methadone initiation and adjusting the dose to a good treatment dose the standard of care, the default for patients that are interested who need it when they're hospitalized. It's just a touch point that we can't miss. We know from research about opioid use disorder and opioid overdose that we do have these critical touch with patients that are our chance to deliver evidence based treatment, to address overdose prevention, to address other issues like HIV prevention in some cases.

Dr. Jessica Taylor:

So, I can just say that it's, first of all, necessary. It's right for our patients. It's incredibly rewarding because in a hospital setting, you're not limited to a 72 hour restriction. There are not restrictions on treating opioid use disorder in a hospitalized patient that's admitted for a medical reason. And so, being able to start a dose, adjust the dose, according to clinical need, as opposed to according to very specified regulation is really rewarding.

Dr. Jessica Taylor:

Patients appreciate it, it's a monitored setting where we can often increase the dose faster than can happen at an outpatient opioid treatment program, and it tends to go very well. And I think the reason that we've been able to so quickly stand up this pathway through our bridge clinic that relies upon direct admissions is that we had the experience from doing this from our inpatient service to the opioid treatment programs and had really, as Alex was saying, developed trust, developed bidirectional communication. We have names and phone numbers of the people we need to talk to if we have a challenging referral. They can get a hold of me or the nurse care manager in our setting. So, really going across institution and across care systems is what's called for here, and it can be really rewarding and incredibly beneficial to patients once you get through the start up challenge of building these bridges and connections.

Dr. Alex Walley:

So, this podcast is not just focused on opioid use disorder, but also in HIV and HIV prevention. We've talked about the benefits of methadone in HIV and HIV prevention, but I think we should reiterate just again so people understand the connection here. So, how does increasing access, improving direct admission to methadone treatment; how does that help us treat and prevent HIV?

Dr. Jessica Taylor:

Methadone is an HIV prevention intervention. So, we have data, from many years, actually showing that when people who do not have HIV start methadone, their risk of getting HIV in the future goes down, and probably that happens through a number of different pathways. That could include methadone decreasing of times someone injects and uses injection drugs. It could include decreasing sexual risk. For people who are already living with HIV, it can include stabilizing an opioid use disorder and that making it easier to take antiretroviral therapy or HIV medicine every day, which then has prevention benefits in the community.

Dr. Alex Walley:

It increases contact with healthcare. There's increased opportunity to do testing, to deliver HIV prevention messages, to empower people to make their own healthcare and risk behavior decisions.

Dr. Jessica Taylor:

Absolutely. All of those things. When we talk about HIV prevention, we often run down a list that may be familiar to folks on the call. We think about condoms. We think about HIV pre-exposure prophylaxis and post-exposure prophylaxis, PrEP and PEP. We think about treatment as prevention, many others. But I think we often leave medications for opioid use disorder out of that conversation, and that's really a missed opportunity because the evidence for medications like methadone is quite strong for HIV prevention. And really, to address what are now being described as syndemics, the epidemics of opioid use disorder, as well as increasing HIV transmission, among people who inject drugs; we have to think about these things together and deliver the services in an integrated way. Because the old system of this siloed care just is system-centered, not patient-centered, and it really hasn't gotten us to the goal of preventing HIV transmission or preventing opioid overdose.

Dr. Alex Walley:

So, Jess, what do you thinks next? What are we going to talk about next about methadone when we have the chance again?

Dr. Jessica Taylor:

Well, knowing us, it will come up again. The latest development has been guidance from the DEA that will allow programs who are not opioid treatment programs to not only use the 72 hour rule, which we're already doing in our bridge clinic, but actually to dispense a three day supply at once. Meaning, patients can take methadone home, up to a three day supply, to bridge them between an acute care episode or an episode of opioid withdrawal and starting at the methadone clinic. And so, that's something that's very different than how we're practicing now, where all of the doses of methadone that we're using for opioid withdrawal are directly administered in the clinic to a patient who's physically sitting with us in our clinic, and I think opens up a lot of opportunity and really meets an unmet need for patients that may, for example, be admitted to the hospital, able to start at a methadone clinic on Monday, it's Friday, and need a supply of methadone to get them through the weekend to get to that first clinic visit.

Dr. Jessica Taylor:

So Alex, I think you and I both have submitted the request to the DEA to be approved in order to provide the service. I'm still waiting for my letter. I don't know if you've gotten yours yet.

Dr. Alex Walley:

I'm still waiting, too.

Dr. Jessica Taylor:

But hopefully soon we'll have an update on that and we can share with the group how that's going in early days in our programs.

Dr. Alex Walley:

Yep. They made very clear; it's dispensed, but not prescribed, and so that parts interesting. And I agree, I think it opens up opportunities to innovate. I haven't exactly figured out how to make it smooth, but we'll be working on that.

Dr. Alex Walley:

I really enjoyed this opportunity to geek out with you on methadone today. I promise we will talk more about methadone, but I also promise we will talk about other topic at future podcasts. We got technical today, and I want to just encourage people to go to the show page and check out the links that we have to some of the regulations, and we'll add some more helpful documents so that people who want to learn more, who also want to geek out on methadone and methadone regulation and direct admission, can find those resources.

Dr. Alex Walley:

It's really a pleasure today, and I look forward to the next time.

Dr. Jessica Taylor:

Thanks, Alex.

Dr. Alex Walley:

You're listening to Connecting Care. Our program was produced today by JSI and Boston Medical Center. Connecting Care is supported by the HRSA-funded project, Strengthening Systems of Care for People with HIV and Opioid Use Disorder. The project aims to enhance system level coordination and networks of care among Ryan White HIV/AIDS program recipients, and other federal, state, and local entities. You can learn more about the project and find resources at www.SSC.JSI.com.